EXECUTIVE SUMMARY

PURPOSE:

To determine the usefulness of HMO disenrollment rates as performance indicators of Medicare risk HMOs, in light of our recent beneficiary survey data.

BACKGROUND AND METHODOLOGY:

The rapidly increasing participation of Medicare and Medicaid beneficiaries in managed care has heightened the need to find valid measures and performance indicators for HMOs. Two measures which have been considered by researchers and policy analysts are HMO disenrollment rates and direct surveys of HMO members. We previously reported results from a survey of 2,882 enrolled and disenrolled beneficiaries in 45 Medicare risk HMOs. Using our survey data, coupled with disenrollment data for these HMOs, we conducted both beneficiary and HMO-level analyses to assess the validity of using disenrollment rates as indicators of HMO performance, and participant survey data to predict disenrollment. This report presents our analyses and conclusions regarding the viability of these two performance indicators.

FINDINGS

Disenrollment Rates as a Performance Indicator

HMO disenrollment rates, once properly adjusted, may provide an early alert of possible problems among Medicare risk HMOs. HMOs with higher disenrollment rates had more enrollees who reported service access problems. However, the following adjustments to HMO disenrollment rates are needed to accurately reflect HMO trends:

- Annualize the rates to more accurately portray disenrollment activity among newer HMO risk contracts.
- Adjust rates for administrative disenrollments (e.g. beneficiaries moving out of the service area).
- Recognize disenrollment rates will be understated because they do not capture those beneficiaries who want to leave but cannot.

HMO Disenrollment Patterns

HMOs with more experience in the Medicare risk HMO program experienced the largest decreases in their disenrollment rates over time.

Beneficiary Disenrollment Patterns

Beneficiary-level survey data showed beneficiaries who are more likely to disenroll tend to report: 1) declining health due to HMO care; 2) being disabled or having end-stage renal disease (ESRD); 3) perceiving that their HMO places more importance on holding down the cost of care rather than giving the best medical care possible; and 4) experiencing long waits in a primary HMO doctor's office.

Beneficiaries leaving Medicare risk HMOs often re-enroll directly, or shortly thereafter, in another HMO.

RECOMMENDATIONS

HMO disenrollment rates, in conjunction with beneficiary survey data, appear to be useful HMO performance indicators. Overall, we recommend that HCFA use systematically developed HMO disenrollment rates and beneficiary survey data to improve its monitoring activities. We believe this is a particularly important step in light of the anticipated rapid growth of the Medicare risk HMO program. We specifically recommend that HCFA:

Use Disenrollment Data

- ***Track disenrollment rates over time*** to detect potential problems among HMOs.

- ***Use adjusted disenrollment rates***, along with other available HMO information (e.g. beneficiary complaints and appeals lodged against HMOs) to target reviews of HMOs. Adjustments must include: 1) annualizing rates for Medicare risk HMO contracts less than 2 years old to more accurately measure newer HMOs' disenrollment activity, and 2) excluding administrative disenrollees, which overstate disenrollment rates due to such factors as enrollees moving or HMO plan discontinuation.

- ***Conduct disenrollment surveys*** that fully capture all the beneficiary's reasons for leaving the Medicare risk HMO.

Use Beneficiary Survey Data

- ***Survey enrollees systematically and routinely*** on key questions and on their desire to leave/remain with an HMO, to complement disenrollment data. Such survey data might be captured nationally, to assist in targeting HMOs for in-depth reviews, or in the HMOs which have been targeted as part of the in-depth review itself.

- ***Monitor Medicare risk HMOs with high disenrollment rates and reported service access problems*** and work with HMOs to respond to the needs of beneficiaries at risk of disenrolling. This should include activities that: 1) give more attention to the care delivered to disabled/ESRD beneficiaries; 2) reduce the waiting times in

primary HMO doctor offices; and 3) address HMO practices that cause beneficiaries to report declining health status as a result of their HMO care and their sense that the HMO gives too much priority to holding down costs versus giving the best care.

Use Key Questions

Several key questions successfully predicted future disenrollment and HMO disenrollment rates, along with beneficiaries who wanted to leave but felt they could not.

- ***The questions we found most predictive of beneficiaries' future disenrollment included:***
  - Were complaints taken seriously by their HMO doctors?
  - Did their primary HMO doctors provide Medicare services, admit them to the hospital, or refer them to a specialist when needed?
  - Did they perceive their HMOs as giving too high a priority to holding down the cost of medical care compared to giving the best medical care?
  - Did they perceive their health got worse as a result of the medical care they received in their HMO?
  - Did they experience long waits (1 hour or more) in their primary HMO doctors' offices?

AGENCY COMMENTS

HCFA concurred with the report's recommendations. They noted several projects underway by the Office of Managed Care (OMC) and other work groups addressing many of the recommendations. We applaud their efforts. We would emphasize the importance of conducting systematic and ongoing national surveys that are statistically sound and contain a sufficient representation from individual Medicare HMOs to obtain comparable, nonbiased data.